EXHIBIT 191

NOTIFICATION TO SUPPLIER THAT HAS CEASED OR IS CEASING OPERATION

(**Date**)

Provider/Supplier Name
Address
City, State, ZIP Code

Dear (**Provider/Supplier Name**):

RE: Provider Number (**Provider Number**)

We have been notified that your (**facility type**) (**closed, will close**) on (**date of closing**). Therefore, your participation in the Medicare program (**terminated, will terminate**) effective with that date. No payment can be made under the Medicare program for services rendered on or after (**date of closing**)

Since this action may be of interest to the public, we will publish a notice in the local newspaper with the widest circulation as soon as possible. The notice will give the effective date of termination and the state that payment for (**facility type**) services will not be made on or after that date.* This action will be made known to professional users of your services.

If your (**facility type**) is reopened and you again wish to be covered under the Medicare program, you should contact the (**State agency**). They will assist you to become approved for coverage of your services.

Please let us know if you have any questions concerning this action.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

*Newspaper notification optional